



**Karin Edwards, Certified Advanced Rolfer™**  
**Awakennings: 1016 SE 12<sup>th</sup>, 1.5 blocks south of Belmont**  
**503-230-0087 \*\*\*Door code 1303\*\*\***

Health Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
 \_\_\_\_\_ Zip: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Email: \_\_\_\_\_  
 (Cell) \_\_\_\_\_

Mark any that apply, and add a description if appropriate.

Heart condition	Y	N	Respiratory problems	Y	N
High/low blood pressure	Y	N	Circulatory problems	Y	N
Blood clot / vein disorder	Y	N	Digestive problems	Y	N
Diabetes	Y	N	Eliminatory problems	Y	N
Hearing loss	Y	N	Jaw tension or TMJ	Y	N
Cancer	Y	N	Headaches	Y	N
Thyroid problems	Y	N	Migraines	Y	N
Osteoporosis	Y	N	Sleep trouble	Y	N
Arthritis	Y	N	Sleep positions: _____		
HIV/AIDS or Hepatitis	Y	N	Sensitive to: _____		
Pregnant	Past / Present / Never		Other: _____		

Are you presently under the care of an MD, naturopath, chiropractor, therapist, or acupuncturist? \_\_\_\_\_

If yes, for what? \_\_\_\_\_ Provider's Name \_\_\_\_\_

What medication have you taken in the past six months? \_\_\_\_\_

Please describe any past injuries, accidents and surgeries:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List any areas of body discomfort: \_\_\_\_\_

How do you use your body? Please list current diet, exercise, sports, hobbies or musical instruments.  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you received, or do you regularly receive some form of massage/bodywork? How often?  
 \_\_\_\_\_

Have you ever received Rolfig® before? If so, how many sessions? \_\_\_\_\_

What would you like to gain from your experience with Rolfig®? \_\_\_\_\_

Will you seek reimbursement from an auto claim, health insurance, flex plan account, etc? Y/N

How did you hear about me? \_\_\_\_\_

# Consent for Rolwing® Structural Integration

I hereby request to receive sessions in *Rolwing® Structural Integration* for myself, or for a child for whom I am the legal guardian.

I understand that the purpose of Rolwing® is to balance and align the physical body so that it is supported by gravity in three-dimensional space. This is done through direct manipulation and education so that greater economy and freedom of body movement are achieved.

I understand that Rolwing® is not involved with the treatment of disease of any kind, nor does it substitute for medical diagnosis or treatment when such attention is needed. The Rolfer™ does not treat, prescribe or diagnose an illness, disease, or any other physical or mental disorder of the person. Nothing said or done by a Rolfer™ should be misconstrued to be such.

I understand it is necessary for the Rolfer™ to touch my body in order to assist me in establishing balance and alignment in the body.

I give Karin, as a Certified Advanced Rolfer™, my permission and consent to do all those things necessary in helping me establish balance and alignment, including, but not limited to touching my body. I give the Rolfer full privilege and license to work on my body in such a way as to restore and establish balance and alignment therein.

Furthermore, I understand that any relief of physical or emotional symptoms may or may not occur in conjunction with the organization of the total human being and is not the basic goal of Rolwing®.

I understand that I will be charged for missed sessions with less than **24 hours notice**. \_\_\_\_\_  
(If you are ill, please call or text me with as much notice as possible.) (initials)

\_\_\_\_\_  
Client Signature (or parent/guardian if under 18 years of age)

\_\_\_\_\_  
Date

## Permission to share my health information (optional)

I give permission to discuss my health care treatment with my **health providers**, listed on the first page of this form.

For **motor vehicle claims**, I give permission for my chart notes and other health information to be shared as needed.

\_\_\_\_\_  
Client Signature (or parent/guardian if under 18 years of age)

\_\_\_\_\_  
Date